General

Guideline Title

(1) U.S. medical eligibility criteria for contraceptive use, 2010: adapted from the World Health Organization medical eligibility criteria for contraceptive use, 4th edition. (2) Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of contraceptive methods during the postpartum period. (3) Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of hormonal contraception among women at high risk for HIV infection or infected with HIV.

Bibliographic Source(s)

Centers for Disease Control and Prevention (CDC). U.S. medical eligibility criteria for contraceptive use, 2010: adapted from the World Health Organization medical eligibility criteria for contraceptive use, 4th edition. MMWR Recomm Rep. 2010 Jun 18;59(RR-4):1-86. [969 references] PubMed

Centers for Disease Control and Prevention (CDC). Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of contraceptive methods during the postpartum period. MMWR Morb Mortal Wkly Rep. 2011 Jul 8;60(26):878-83. [10 references] PubMed

Centers for Disease Control and Prevention (CDC). Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of hormonal contraception among women at high risk for HIV infection or infected with HIV. MMWR Morb Mortal Wkly Rep. 2012 Jun 22;61:449-52. [8 references] PubMed

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Note from the Centers for Disease Control and Prevention (CDC) and the National Guideline Clearinghouse (NGC): This guidance will be updated as new evidence becomes available. Please check the CDC's Division of Reproductive Health Web site for any changes that have been made to the recommendations since this guideline was published.

How to Use This Document

These recommendations are intended to help health care providers determine the safe use of contraceptive methods among women and men with

various characteristics and medical conditions. Providers also can use the synthesis of information in these recommendations when consulting with women, men, and couples about their selection of contraceptive methods. The tables in this document include recommendations for the use of contraceptive methods by women and men with particular characteristics or medical conditions. Each condition was defined as representing either an individual's characteristics (e.g., age, history of pregnancy) or a known preexisting medical/pathologic condition (e.g., diabetes and hypertension). The recommendations refer to contraceptive methods being used for contraceptive purposes; the recommendations do not consider the use of contraceptive methods for treatment of medical conditions because the eligibility criteria in these cases may differ. The conditions affecting eligibility for the use of each contraceptive method were classified under one of four categories (Box 1).

Box 1. Categories of Medical Eligibility Criteria (MEC) for Contraceptive Use

1 = A condition for which there is no restriction for the use of the contraceptive method.
2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.
3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.
4 = A condition that represents an unacceptable health risk if the contraceptive method is used.

Using the Categories in Practice

Health care providers can use these categories when assessing the safety of contraceptive method use for women and men with specific medical conditions or characteristics. Category 1 comprises conditions for which no restrictions exist for use of the contraceptive method. Classification of a method/condition as Category 2 indicates the method generally can be used, but careful follow-up may be required. For a method/condition classified as Category 3, use of that method usually is not recommended unless other more appropriate methods are not available or acceptable. The severity of the condition and the availability, practicality, and acceptability of alternative methods should be taken into account, and careful follow-up will be required. Hence, provision of a method to a woman with a condition classified as Category 3 requires careful clinical judgment and access to clinical services. Category 4 comprises conditions that represent an unacceptable health risk if the method is used. For example, a smoker aged <35 years generally can use combined oral contraceptives (COCs) (Category 2). However, for a woman aged ≥35 years who smokes <15 cigarettes per day, the use of COCs usually is not recommended unless other methods are not available or acceptable to her (Category 3). A woman aged ≥35 years who smokes ≥15 cigarettes per day should not use COCs because of unacceptable health risks, primarily the risk for myocardial infarction and stroke (Category 4). The programmatic implications of these categories may depend on the circumstances of particular professional or service organizations (e.g., in some settings, a Category 3 may mean that special consultation is warranted).

The recommendations address medical eligibility criteria for the initiation and continued use of all methods evaluated. The issue of continuation criteria is clinically relevant whenever a woman develops the condition while she is using the method.

When the categories differ for initiation and continuation, these differences are noted in the columns Initiation and Continuation. Where Initiation and Continuation are not denoted, the category is the same for initiation and continuation of use.

On the basis of this classification system, the eligibility criteria for initiating and continuing use of a specific contraceptive method are presented in tables (Appendices A–M in the original guideline document). In these tables, the first column indicates the condition. Several conditions were divided into subconditions to differentiate between varying types or severity of the condition. The second column classifies the condition for initiation and/or continuation into Category 1, 2, 3, or 4. For some conditions, the numeric classification does not adequately capture the recommendation; in this case, the third column clarifies the numeric category. These clarifications were determined during the discussions of the scientific evidence and the numeric classification and are considered a necessary element of the recommendation. The third column also summarizes the evidence for the recommendation, where evidence exists. The recommendations for which no evidence is cited are based on expert opinion from either the World Health Organization (WHO) or U.S. expert working group meetings and may be based on evidence from sources other than systematic reviews and presented at those meetings. For selected recommendations, additional comments appear in the third column and generally come from WHO or the U.S. expert working group participants.

Recommendations for Use of Contraceptive Methods

The classifications for whether women with certain medical conditions or characteristics can use specific contraceptive methods are provided in several appendices in the original guideline document for the following contraceptive methods:

- Combined hormonal contraceptive methods, including lose-dose (containing ≤35 micrograms of ethinyl estradiol) combined oral contraceptive pills, combined hormonal patch, and combined vaginal ring (Appendix B)
- Progestin-only contraceptive methods, including progestin-only pills, depot medroxyprogesterone acetate injections, and etonogestrel

implants (Appendix C)
- Emergency contraceptive pills (Appendix D)
- Intrauterine contraception, including the copper intrauterine device (IUD) and the levonorgestrel IUD (Appendix E)
- Use of copper IUDs for emergency contraception (Appendix F)
- Barrier contraceptive methods, including male and female condoms, spermicides, diaphragm with spermicide, and cervical cap (Appendix G)
- Fertility awareness-based methods (Appendix H)
- Lactational amenorrhea method (Appendix I)
- Coitus interruptus (withdrawal) (Appendix J)
- Female and male sterilization (Appendix K)

Tables at the end of the document summarize the classifications for the hormonal and intrauterine methods (Appendix L) and the evidence about potential drug interactions between hormonal contraceptives and antiretroviral therapies (Appendix M).

Contraceptive Method Choice

Many elements need to be considered by women, men, or couples at any given point in their lifetimes when choosing the most appropriate contraceptive method. These elements include safety, effectiveness, availability (including accessibility and affordability), and acceptability. The guidance in this document focuses primarily on the safety of a given contraceptive method for a person with a particular characteristic or medical condition. Therefore, the classification of Category 1 means that the method can be used in that circumstance with no restrictions with regard to safety but does not necessarily imply that the method is the best choice for that person; other factors, such as effectiveness, availability, and acceptability, may play a key role in determining the most appropriate choice. Voluntary informed choice of contraceptive methods is an essential guiding principle, and contraceptive counseling, where applicable, may be an important contributor to the successful use of contraceptive methods.

In choosing a method of contraception, the risk for sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), also must be considered. Although hormonal contraceptives and IUDs are highly effective at preventing pregnancy, they do not protect against STIs. Consistent and correct use of the male latex condom reduces the risk for STIs. When a male condom cannot be used properly for infection prevention, a female condom should be considered. Women who use contraceptive methods other than condoms should be counseled about the use of condoms and the risk for STIs. Additional information about prevention and treatment of STIs is available from CDC's Sexually Transmitted Diseases Treatment Guidelines (http://www.cdc.gov/std/treatment).

2011 Addendum

Recently, CDC assessed evidence regarding the safety of combined hormonal contraceptive use during the postpartum period. This report summarizes that assessment and the resulting updated guidance. These updated recommendations state that postpartum women should not use combined hormonal contraceptives during the first 21 days after delivery because of the high risk for venous thromboembolism (VTE) during this period. During 21–42 days postpartum, women without risk factors for VTE generally can initiate combined hormonal contraceptives, but women with risk factors for VTE (e.g., previous VTE or recent cesarean delivery) generally should not use these methods. After 42 days postpartum, no restrictions on the use of combined hormonal contraceptives based on postpartum status apply.

See the text of the 2011 addendum for complete recommendations for use of combined hormonal contraceptives during the postpartum period and for use of other contraceptive methods during the postpartum period.

2012 Addendum

Recently, CDC assessed the evidence regarding hormonal contraceptive use and the risk for human immunodeficiency virus (HIV) acquisition, transmission, and disease progression. This report summarizes that assessment and the resulting updated guidance. These updated recommendations affirm the previous guidance, which stated that 1) the use of hormonal contraceptives, including combined hormonal contraceptives, progestin-only pills, depot medroxyprogesterone acetate (DMPA), and implants, is safe for women at high risk for HIV infection or infected with HIV (US MEC category 1), and 2) all women who use contraceptive methods other than condoms should be counseled regarding the use of condoms and the risk for sexually transmitted infections. However, a clarification is added to the recommendation for women at high risk for HIV infection who use progestin-only injectables to acknowledge the inconclusive nature of the body of evidence regarding the association between progestin-only injectable use and HIV acquisition. The clarification also notes the importance of condom use and other HIV preventive measures, expansion of the variety of contraceptive methods available (i.e., contraceptive method mix), and the need for further research on these issues.

See the text of the 2012 addendum for recommendations for contraceptive use by women who are at high risk for HIV infection, or who have HIV infection, or who have acquired immunodeficiency syndrome (AIDS).

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Unintended pregnancy

Guideline Category

Assessment of Therapeutic Effectiveness

Counseling

Evaluation

Management

Prevention

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Infectious Diseases

Internal Medicine

Nursing

Obstetrics and Gynecology

Pediatrics

Pharmacology

Preventive Medicine

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Other

Pharmacists

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

2010 Guideline

- To provide recommendations for the use of specific contraceptive methods by women and men who have certain characteristics or medical conditions
- To assist health-care providers when they counsel women, men, and couples about contraceptive method choice

2011 Addendum

To summarize the Centers for Disease Control and Prevention (CDC) assessment of evidence regarding the safety of combined hormonal contraceptive use during the postpartum period and the resulting updated guidance

2012 Addendum

To summarize the CDC assessment of evidence regarding hormonal contraceptive use and the risk for human immunodeficiency virus (HIV) acquisition, transmission, and disease progression and the resulting updated guidance

Target Population

2010 Guideline

Women and men with certain characteristics or medical conditions who are choosing a contraceptive method. These characteristics and conditions include the following categories:

- Personal characteristics and reproductive history
- Cardiovascular disease
- Rheumatic disease
- Neurologic conditions
- Depressive disorders
- Reproductive tract infections and disorders
- Other infections
- Endocrine conditions
- Gastrointestinal conditions
- Anemias
- Solid organ transplantation
- Drug interactions

2011 Addendum

Women choosing a contraceptive method during the postpartum period

2012 Addendum

Women at risk for human immunodeficiency virus (HIV) infection or infected with HIV who are choosing a contraceptive method

Interventions and Practices Considered

Contraceptive methods:

- Combined hormonal contraceptives, including pill, patch, and ring
- Progestin-only contraceptives: progestin-only pills, depot medroxyprogesterone acetate, and progestin-only implants
- Emergency contraceptive pills: levonorgestrel and combined oral contraceptive pills

- Intrauterine devices (IUD): levonorgestrel-releasing (20 micrograms/24 hours) IUD and the copper-bearing IUD
- Copper IUDs for emergency contraception
- Barrier methods: male latex condoms, male polyurethane condoms, and female condoms; spermicides; and diaphragm with spermicide or cervical cap
- Fertility awareness-based (FAB) methods: involve identifying the fertile days of the menstrual cycle, whether by observing fertility signs such as cervical secretions and basal body temperature or by monitoring cycle days
- Lactational amenorrhea method
- Coitus interruptus (withdrawal)
- Sterilization: tubal sterilization for women and vasectomy for men

Major Outcomes Considered

- Effectiveness of contraceptive methods
- Safety of contraceptive methods
- Unintended pregnancy rate

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Centers for Disease Control and Prevention (CDC) conducted systematic reviews following standard guidelines, included thorough searches of PubMed and other databases of the scientific literature, and used the U.S. Preventive Services Task Force (USPSTF) system to grade the strength and quality of the evidence.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Weighting According to a Rating Scheme (Scheme Not Given)

Rating Scheme for the Strength of the Evidence

The Centers for Disease Control and Prevention (CDC) used the U.S. Preventive Services Task Force (USPSTF) system to grade the strength and quality of the evidence.

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

A systematic review of the scientific evidence was conducted for each of the World Health Organization (WHO) recommendations considered for adaptation and for each of the medical conditions considered for addition to the guidance. The purpose of these systematic reviews was to identify direct evidence about the safety of contraceptive method use by women (or men) with selected conditions (e.g., risk for disease progression or other adverse health effects in women with rheumatoid arthritis who use combined oral contraceptives). Information about indirect evidence (e.g., evidence from healthy women or animal studies) or theoretical considerations was obtained when direct evidence was not available.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

2010 Guideline

The process for adapting the World Health Organization (WHO) medical eligibility criteria (MEC) for the United States (U.S.) comprised four major steps: 1) determination of the scope of and process for the adaptation, including a small meeting; 2) preparation and peer review of systematic reviews of the evidence to be used for the adaptation; 3) organization of a larger meeting to examine the evidence and provide input on the recommendations; and 4) finalization of the recommendations by Centers for Disease Control and Prevention (CDC).

In June 2008, CDC held a 2-day meeting of eight key partners and U.S. family planning experts to determine the scope of and process for a U.S. adaptation of the WHO MEC. Participants were family planning providers, who also had expertise in conducting research on contraceptive safety and translating research evidence into guidance. WHO guidance is used widely around the world, including in the United States, and contains approximately 1,800 separate recommendations. In most cases, the evidence base would be the same for the U.S. and the WHO recommendation, and—because of the extensive collaboration between WHO and CDC in creating the international guidance—the process for determining the recommendations also would be the same. Therefore, CDC determined that the global guidance also should be the U.S. guidance, except when a compelling reason existed for adaptation, and that CDC would accept the majority of WHO guidance for use in the U.S.

During the June 2008 meeting, CDC identified specific WHO recommendations for which a compelling reason existed to consider modification for the U.S. because of the availability of new scientific evidence or the context in which family planning services are provided in the U.S. CDC also identified areas in which WHO guidance was inconsistent with current U.S. practice by contacting numerous professional and service organizations and individual providers. In addition, CDC assessed the need for adding recommendations for medical conditions not currently included in the WHO MEC. Through this process, a list was developed of existing WHO recommendations to consider adapting and new medical conditions to consider adding to the guidance.

For most recommendations in this document, a limited number of studies address the use of a specific contraceptive method by women with a specific condition. Therefore, within the WHO guidance, as well as with this U.S. adaptation of the guidance, most of the decisions about medical eligibility criteria were often necessarily based on: 1) extrapolations from studies that primarily included healthy women, 2) theoretical considerations about risks and benefits, and 3) expert opinion. Evidence was particularly limited for newer contraceptive methods. The total body of evidence for each recommendation included evidence based on direct studies or observations of the contraceptive method used by women (or men) with the condition and may have included: 1) evidence derived from effects of the contraceptive method used by women (or men) without the condition and 2) indirect evidence or theoretical concerns based on studies of suitable animal models, human laboratory studies, or analogous clinical situations.

Note: The majority of the United States (U.S.) guidance does not differ from the World Health Organization (WHO) guidance and covers >60 characteristics or medical conditions. However, some WHO recommendations were modified for use in the U.S., including recommendations about contraceptive use for women with venous thromboembolism, valvular heart disease, ovarian cancer, and uterine fibroids and for postpartum and breastfeeding women. Recommendations were added to the U.S. guidance for women with rheumatoid arthritis, history of bariatric surgery, peripartum cardiomyopathy, endometrial hyperplasia, inflammatory bowel disease, and solid organ transplantation.

2011 Addendum

In 2010, based on new evidence, WHO updated its guidance on the safety of combined hormonal contraceptives among postpartum nonbreastfeeding women to be more restrictive regarding the use of combined hormonal contraceptives during the first 42 days postpartum, particularly among women with other risk factors for venous thromboembolism (VTE). Recommendations for breastfeeding women were not changed. Because of this WHO update, CDC initiated a process to assess whether its guidance similarly should be updated. Before this process, US MEC recommended that women less than 21 days postpartum generally should not use combined hormonal contraceptives, but that after that

time, combined hormonal contraceptives could be used without restriction.

From a systematic review conducted by WHO and CDC and used in the consultation to update the WHO guidance, evidence from 13 studies showed that the risk for VTE among women within the first 42 days postpartum is 22-fold to 84-fold greater than the risk among nonpregnant, nonpostpartum reproductive age women. The risk is highest immediately after delivery, declining rapidly during the first 21 days, but not returning to baseline until 42 days postpartum in most studies. Use of combined hormonal contraceptives, which can cause a small increased risk for VTE in healthy reproductive age women, might theoretically pose an additional risk if used during this time. However, no evidence was identified regarding risk for VTE among postpartum women using combined hormonal contraceptives. The evidence also is limited by the small number of studies that report risk for VTE at precise intervals during the postpartum period and report baseline risk for VTE in a reference population for comparison with the risk among postpartum women. Evidence also was examined regarding the return to fertility among nonbreastfeeding postpartum women and indicated that ovulation can occur as early as 25 days postpartum, although fertile ovulation likely will not occur until at least 42 days postpartum.

As part of the CDC assessment, CDC recruited 13 persons from outside the agency to serve as ad hoc reviewers of the WHO revised recommendations; they were selected based on their expertise in thromboembolic disease, hematology, and family planning. The reviewers were asked to participate in a January 2011 teleconference with CDC, during which participants would review the evidence base and assess whether WHO's revised recommendations were suitable for use in the United States. A key issue identified was that immediate postpartum use of combined hormonal contraceptives would impose a high risk for VTE without any substantial benefit in pregnancy prevention because most nonlactating women will not have a fertile ovulation until at least 42 days postpartum. Women with risk factors for VTE in addition to being postpartum (e.g., obesity or cesarean delivery) are already at elevated risk for VTE; use of combined hormonal contraceptives theoretically would further compound that risk. Finally, access to contraceptive methods was a concern of the group; however, unlike methods that require a visit to a provider (e.g., implants and intrauterine devices [IUDs]), combined hormonal contraceptives can be started by the woman herself at the appropriate time if given a prescription or sample in advance (either before hospital discharge or at a postpartum visit).

2012 Addendum

In February 2012, based on new evidence, WHO affirmed its previous guidance on the safety of hormonal contraceptives among women at high risk for human immunodeficiency virus (HIV) infection and those living with HIV infection and clarified its recommendation on the use of progestin-only injectables by women at high risk for HIV infection. Because of this update, CDC initiated a process to assess whether its guidance should be updated similarly.

CDC invited seven participants from outside the agency and two participants from inside the agency to serve as ad hoc reviewers of the evidence and the WHO revised recommendations. The reviewers were selected based on their expertise in HIV infection or family planning. The reviewers participated in a March 2012 teleconference with CDC during which they reviewed and discussed the scientific evidence base, as well as information on unintended pregnancy, contraceptive use, HIV infection, and maternal risk in the United States. Finally, the reviewers provided their individual perspectives regarding whether WHO's revised recommendations were suitable for use in the United States. The reviewers considered the evidence, the conclusions from the WHO consultation, and how the WHO recommendations might apply to the United States. Although acknowledging that the United States context differs from the global context in a number of ways (e.g., lower HIV incidence and prevalence; greater access to health-care services, including contraceptive methods, antiretroviral therapy, and HIV testing and counseling; and lower pregnancy-related risks), the individual reviewers strongly and consistently favored adopting the WHO revised recommendations.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

In February 2009, Centers for Disease Control and Prevention (CDC) held a meeting of 31 experts who were invited to provide their individual perspective on the scientific evidence presented and the discussions on potential recommendations that followed. This group included obstetricians/gynecologists, pediatricians, family physicians, nurse-midwives, nurse practitioners, epidemiologists, and others with expertise in contraceptive safety and provision. For each topic discussed, the evidence from the systematic review was presented; for most of the topics, an expert in the specific medical condition (e.g., rheumatoid arthritis) also gave a brief presentation on the condition and specific issues about contraceptive safety. CDC gathered input from the experts during the meeting and finalized the recommendations.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence is not specifically stated for each recommendation.

The third column in Appendices A-M in the full version of the original guideline document summarizes the evidence for the recommendations, where evidence exists. The recommendations for which no evidence is cited are based on expert opinion from either the World Health Organization (WHO) or U.S. expert working group meetings, and may be based on evidence from sources other than systematic reviews and presented at those meetings.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Through a collaborative approach to developing and implementing common clinical practice guidelines and performance measures for prevention of unintended pregnancy in adults (women or men) with selected conditions, Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) will achieve consistent delivery of evidence-based services and better health outcomes.
- These recommendations will assist health care providers when they counsel women, men, and couples about contraceptive method choice.

Potential Harms

- The risks associated with use of various contraceptive methods in individuals with specific medical conditions or characteristics (including potential for drug interactions) are summarized in Appendices B through K of the original guideline document.
- Drug interactions between combined oral contraceptive (COCs) and antiretroviral (ARV) drugs are summarized in Appendix M, Table 1 of the original guideline document.
- Drug interactions between depot medroxyprogesterone acetate (DMPA) and ARV drugs are summarized in Appendix M, Table 2 of the original guideline document.

Qualifying Statements

Qualifying Statements

- This document contains recommendations for health-care providers for the safe use of contraceptive methods by women and men with various characteristics and medical conditions. It is intended to assist health-care providers when they counsel women, men, and couples about contraceptive method choice. These recommendations are meant to be a source of clinical guidance; health-care providers should always consider the individual clinical circumstances of each person seeking family planning services.
- The recommendations refer to contraceptive methods being used for contraceptive purposes; the recommendations do not consider the use of contraceptive methods for treatment of medical conditions because the eligibility criteria in these cases may differ.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Centers for Disease Control and Prevention (CDC). U.S. medical eligibility criteria for contraceptive use, 2010: adapted from the World Health Organization medical eligibility criteria for contraceptive use, 4th edition. MMWR Recomm Rep. 2010 Jun 18;59(RR-4):1-86. [969 references] PubMed

Centers for Disease Control and Prevention (CDC). Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of contraceptive methods during the postpartum period. MMWR Morb Mortal Wkly Rep. 2011 Jul 8;60(26):878-83. [10 references] PubMed

Centers for Disease Control and Prevention (CDC). Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of hormonal contraception among women at high risk for HIV infection or infected with HIV. MMWR Morb Mortal Wkly Rep. 2012 Jun 22;61:449-52. [8 references] PubMed

Adaptation

This guideline is adapted from: World Health Organization (WHO) medical eligibility criteria for contraceptive use. 4th ed. Geneva: WHO; 2009. Available from the WHO Web site .

Date Released

2010 Jun 18 (addenda released 2011 Jul 8 and 2012 Jun 22)

Guideline Developer(s)

Centers for Disease Control and Prevention - Federal Government Agency [U.S.]

Source(s) of Funding

United States Government

Guideline Committee

Centers for Disease Control and Prevention Steering Committee

Composition of Group That Authored the Guideline

2010 Guideline

Chairpersons: Herbert B. Peterson, MD, University of North Carolina, Chapel Hill, North Carolina; Kathryn M. Curtis, PhD, Centers for Disease Control and Prevention, Atlanta, Georgia

Committee Members: Kathryn M. Curtis, PhD (*Chair*); Denise Jamieson, MD; John Lehnherr; Polly Marchbanks, PhD, Centers for Disease Control and Prevention, Atlanta, Georgia

2011 Addendum

Reported by: Naomi K. Tepper, MD; Kathryn M. Curtis, PhD; Denise J. Jamieson, MD; Polly A. Marchbanks, PhD; Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

2012 Addendum

Reported by: Naomi K. Tepper, MD; Kathryn M. Curtis, PhD; Denise J. Jamieson, MD; Polly A. Marchbanks, PhD; Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

Guideline Availability

2010 Guideline

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site .

2011 Addendum

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site .

2012 Addendum

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site .

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

Availability of Companion Documents

A summary chart of the U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 is available from the Centers for Disease Control and Prevention's (CDC's) Division of Reproductive Health Web site .

Patient Resources

A Birth Control Methods Fact Sheet is available in Portable Document Format (PDF) from the Womenshealth.gov Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on February 9, 2011. The information was verified by the guideline developer on March 1, 2011. This NGC summary was updated by ECRI Institute on August 23, 2011 and August 3, 2012.

Copyright Statement

Disclaimer

NGC Disclaimer

The National Guideline Clearinghouseâ„¢ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion-criteria.aspx.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical

practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.